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ABSTRACT

The document summarizes preliminary research findings of the Allied Health Professions Projects regarding social service entry workers in health care services. Preliminary findings suggest job descriptions, task assignments, and training requirements and provide a framework for the project's main objective of developing instructional materials and curricula to teach job skills. Following an overview of the project, discussions of manpower problems in social work and the emergence of new careers are presented. A selected panel of social workers and the Advisory committee identified and rated tasks, skills and knowledges in terms of: criticality, cognitive level, and human interaction; and job levels. Two sub-committees examined ways of differentiating and delineating tasks for the entry-level and two-year college workers and defined the knowledges, skills, and attributes of those tasks. A conceptual model for a career "lattice" for entry-level workers is presented. Results from a national survey are expected to modify present findings. Appended material takes up half the document and includes: committee and sub-committee members list; the social service occupations function list; definition of the rating scales; categorization of level one tasks; and a list of facilities participating in the survey. (LH)

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Interim Report

PRELIMINARY ANALYSIS OF THE SOCIAL SERVICE OCCUPATIONS

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FOREWORD

The Division of Vocational Education, University of California, is an administrative unit of the University concerned with responsibilities for research, teacher education, and public service in the broad area of vocational and technical education. During 1968 the Division entered into an agreement with the U.S. Office of Education to prepare curricula and instructional materials for a variety of allied health areas. For the most part such materials are related to pre-service and in-service instruction in programs from on-the-job instruction through Associate degree programs.

This interim report is a summary of preliminary work in defining the functions of emerging pre-baccalaureate workers in the medical social service occupations. A National Technical Advisory Committee for Social Service, plus a number of expert consultants, provided assistance in designing a research instrument to identify and validate tasks appropriate for social service workers in health care facilities throughout the nation.

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TABLE OF CONTENTS

	Page
FOREWORD	iii
SUMMARY	vii
I. INTRODUCTION	1
II. MANPOWER PROBLEMS IN SOCIAL WORK	2
III. EMERGENCE OF NEW CAREERS	3
IV. DELINEATING FUNCTIONS OF ENTRY-LEVEL WORKERS	4
A. Development of Task List	5
B. Tentative Findings and Recommendations	13
1. Suggested Job Definition and Task Assignment	14
2. Proposed Curriculum for Entry-Level Workers	16
C. A Career Lattice Concept for Entry Workers	17
V. CONCLUSIONS	18
BIBLIOGRAPHY	21
APPENDICES	23
A. National Technical Advisory Committee for Social Service Occupations	23
B. Social Service Occupations Function List	27
C. Definitions of Rating Scales	39
D. Categorization of Level I Tasks	41
E. List of Health Care Facilities Selected for National Survey	45

LIST OF TABLES

Table 1: Summary of Ratings of All Tasks by Respondent Group	6
Table 2: Comparison Levels I and II Tasks	8
Table 3: Ranking of Functional Groups on Scales of Criticality, Cognitive Level, and Human Interaction, as Rated by Panel of Experts	12
Figure 1: Conceptual Model for Career Lattice	19

SUMMARY

OBJECTIVES

1. To summarize activities to date within the project for the social service occupations.

2. To present suggestions for the job description, task assignment and training requirements for the social service entry worker in health as a corollary to the preparation of instructional materials.

PROCEDURES

1. A National Technical Advisory Committee has been established, representing social workers and other disciplines involved with social work activities from various regions of the United States.

2. Task assignments have been delineated for pre-baccalaureate social service workers in health care.

3. Literature relevant to the utilization and training of social service workers in health care has been reviewed.

4. Existing training programs for entry-level social service workers in health and mental health programs have been observed.

SIGNIFICANT FINDINGS AND RECOMMENDATIONS

1. A task inventory for entry-level social service workers has been formulated, based on a task rating performed by the National Technical Advisory Committee and a panel of experts.

2. A suggested job description and task assignment schedule for entry-level workers has been designed from which instructional materials may be developed.

3. Recommendations have been developed for the recruitment and training of entry-level social service workers in health care.

4. The social services division of the Project has conceptualized a career lattice formula for entry-level social workers in health and related programs, providing opportunities for mobility.

5. There is need to identify core areas specific to social service occupations as well as those shared with other allied health occupations.

Interim Report

PRELIMINARY ANALYSIS OF

THE SOCIAL SERVICE OCCUPATIONS

I. INTRODUCTION

The manpower shortage in social work has been a serious problem which continues to challenge the profession. Despite numerous studies of this problem and attempts to identify the necessary steps toward solving it, no solution has been found. Five years ago, the Task Force on Social Work Education and Manpower of the Department of Health, Education, and Welfare issued a disturbing report. This document verified that the sharply widening gap between needed and available social work manpower was threatening continuation of many vital programs and delaying development of necessary services already authorized.[1]

The Department of Health, Education, and Welfare has recognized the crucial need for increased personnel in health care services, including the medical, dental, nursing, and social work fields. To assist in alleviating this shortage of personnel, funds were provided in 1968 by the Office of Education to initiate the UCLA Allied Health Professions Projects, whose objectives are the development of curricula and educational materials for such allied health occupations as can be taught adequately in two-year community college programs leading to the Associate degree. Also included as objectives are the development of in-service and pre-service training for allied health activities commonly taught on the job.

The program, as developed by UCLA in line with the Office of Education's specifications, is analyzing current job practices in a number of allied health occupations. A functional analysis of each selected occupation has been used to determine what is actually being done by workers in the health facility setting. Skilled committees are helping to establish the levels of training and curricula required to develop entry-level workers and provide them with opportunities for advancement based on experience, training and additional education. A career ladder should permit the ambitious and the able to advance in their respective occupations despite initial handicaps.

In short, it should become possible for a person to enter a health occupation at the lowest rung on the ladder and to progress upward through on-the-job and in-service training and through additional formal education at the high school, adult school, or community (junior) college levels. Attention will be given to providing course credit, based on schooling as well as experience.

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[1] Closing the Gap in Social Work Manpower, Report of the Department Task Force on Social Work Education and Manpower. Washington: Department of Health, Education, and Welfare, November, 1965.

This interim report presents the findings of the first year's activities of the Allied Health Professions Projects in the social service occupations. Information gathered during this first year of operation has led to tentative conclusions regarding the position of the social service entry worker in health care services. In addition, a possible curriculum is outlined for this worker, and the tasks in which he is involved are defined to some extent.

A National Advisory Committee, selected from among educators, professional associations, public and private agencies, and the public at large, has served to delineate the overall program of the Allied Health Professions Projects. In addition, each occupation has its own National Technical Advisory Committee made up of experts in that particular field. These include practitioners, educators, users of the services, representatives of national professional associations, and physicians. In social service, the National Technical Advisory Committee was selected to include persons who are not only knowledgeable in the field, but also who represent regional areas and varying practices. (See Appendix A.)

II. MANPOWER PROBLEMS IN SOCIAL WORK

Traditionally, the M.S.W. has been considered the basic professional degree in social work. The graduate schools of social work where this degree is offered are limited not only in number but also in capacity to train an adequate number of social workers. The resulting shortage of manpower has led to utilization of baccalaureate-level workers in social work positions. Despite the fact that a large portion of direct service operations are conducted by workers with a bachelor's degree, many professionals and agencies view this only as stop-gap service, or as a way of recruiting graduate students for social work careers.

Attempts to utilize the four-year graduate as an integral and permanent position in the health service delivery system have been limited. The Veterans Administration was instrumental in establishing the social work assistant position, requiring a baccalaureate degree, some agency training, and the supervision of an M.S.W. The bachelor's level worker now has become an accepted position in many medical social service departments. This has not been true in psychiatric departments, where in most cases only professional (master's level) social work staff has been used. The shortage of professional social workers in psychiatric settings is acute and there is considerable evidence that the growth needs of preventive and treatment programs, as in other areas, are far in excess of the training capacities of the nation's graduate schools of social work.

Despite resistance, however, many of the persons doing social work jobs at a sub-professional level soon will be located in mental health settings, either in primary treatment agencies or in facilities providing prevention or aftercare services. Furthermore, those who currently work in welfare agencies find that their daily routine involves working with a population group beset by all types of social and emotional disorders. Very often, after careful evaluation, the most significant need in agency personnel is found to be for

persons with the sensitivity and patience to work with people; these are not necessarily persons having extensive training. In fact, in situations where patient needs are for maintenance of service and supportive relationship, persons without full professional training have showed remarkable abilities to meet these needs.

The enactment of Medicare and other comprehensive health care legislation which call specifically for the provision of social services also has resulted in increased demands for social work personnel to implement these programs. Grants from the National Institute of Mental Health and other federal funding sources have been made available to graduate schools of social work to help train personnel. These grants have been the major source of financing for many social work students--a significant effort in the solution of manpower shortages. An outcome of the 1960's--the poverty programs and social legislation--has led to innovative developments in the delivery of health care services and the emergence of new health care personnel.

Another significant type of change that is occurring in social work and the field of mental health is the recognition that individuals possessing less than complete professional training can serve an important role in helping persons who are experiencing emotional distress or social and emotional disabilities. Individuals with varying levels of training can provide important services to people in need of help. Increasingly it is seen that ability and opportunity to help people are not confined to the ranks of the professionals who have acquired high levels of specialized training.

III. EMERGENCE OF NEW CAREERS

Effective communication between social workers and the population groups they serve has recently been recognized as important. Language barriers are not the only difficulties. A truly foreign culture cannot be adequately understood, however eager and receptive the worker, without outside assistance. Increasing awareness of this need for some intermediary--some interpreter, as it were--has led to the creation of new careers in the health field. Variously known as health aides, neighborhood family health workers, health assistants, community health aides, indigenous community workers have been recruited at an entry level in their own communities and trained to bridge the gap between the established agency and the client. Since health is by current definition a community affair, these low-income, often disadvantaged, persons also act as personal mediators between the frequently differing health care concepts and goals of client and social worker.

One needs only to peruse the literature on numerous demonstration projects supported by funds from the United States Public Health Service, the Office of Economic Opportunity, the Department of Labor, and others to appreciate the remarkable effectiveness of the community worker in health care service. This is particularly noticeable among population groups usually considered "hard to reach," in urban as well as rural areas. To this entry worker, who brings with him an understanding of the community and life-style of his people, can be attributed a much more successful delivery of service. Because he can communicate easily with his neighbors, he offers a new source of effective manpower for the growing health service needs of the country. However,

this may be, for him, the first opportunity he has had to become a productive member of the community.

It is also important to take into account the necessity for utilization of personnel so that each helping person gives as much as he is competent to give and does not waste time performing tasks that can be done as well or better by others. It is, indeed, a waste of scarce health personnel to perform tasks below one's level of competence, and a source of danger to attempt to offer services beyond one's abilities.

The needs of the individual patient and the community will best be served if each understands the scope of his task and its relation to the tasks of those who work with him. Utilization studies serve an important purpose in delineating different functions and determining the level of training necessary to perform these functions.

At the present time, the community health worker usually is recruited without prior experience or training. He may be given some structured health orientation, possibly some remedial education, and then is put to work. under supervision, to perform specific tasks in a health program. Certain factors may contribute to the inadequacy of this training. Visual aids and other instructional material, such as textbooks, generally are geared both to middle-class values and to middle-class educational levels. They often are not relevant to the life-style of the disadvantaged. Uniform supervision is not always available and supervisors may be unable to relate to the community worker. The training often may be oriented to a specific job and does not provide transferable employment experience.

In spite of the obvious social and economic benefits from the use of pre-professional workers, such as community workers, other problems also require attention. One serious problem is the job itself, which is too often a dead end. The new worker may have been hired without attention to the staff system or a review of job assignments and job description. Furthermore, he may appear as a potential threat to social workers with a bachelor's or master's degree by taking over some of their duties.

Another problem is the absence of standardized education and training which would allow for potential job transferability. So far, there has been no integration or coordination of the community worker programs with the curricula of academic institutions. In order to provide a standardized base of knowledge for entry-level, pre-professional health service workers, a review and evaluation of their roles and functions must be made. Personnel specialists, administrators, and agencies must work together to clarify and formalize positions which can be integrated into current personnel and civil service systems.

IV. DELINEATING FUNCTIONS OF ENTRY-LEVEL WORKERS

The initial activities of the National Technical Advisory Committee for the Social Service occupations largely have been aimed toward finding ways of delineating the functions of entry-level workers. The Committee has provided information and support which permitted the development of some preliminary findings in the social service occupations.

Differentiation of tasks and functions in social work is not very clear for each level of practice. Aides, assistants, and professionals all perform some sort of case management involving interviewing, counseling, making referrals, and other supportive or therapeutic relationships. An implication in their role functioning is that higher-level workers handle the more complex and difficult case situations. Workers with less training, theoretically, provide the more routine and less difficult case services. This assumption offers no guidelines for developing criteria for job level functions and training programs. Furthermore, studies indicate that all functions are performed by all levels of social work practice, with the exception of planning and evaluation. Under a broad interpretation, however, all levels of personnel are, in actuality, also involved to some extent in planning and evaluation.

A. Development of Task List

To ascertain current practices in job or task assignments by social service occupational titles, an inventory of tasks or functions found among job descriptions of medical, psychiatric and public health social workers was prepared and submitted for verification to a panel of experts. This panel consisted of social workers in the three specialized fields. After approval by the Technical Advisory Committee the list, consisting of about 200 tasks, formed the basis for the national occupational survey that is now in process.

Before the Project staff could develop any instructional materials for entry-level workers, it was confronted with the problem of identifying the tasks, functions, and skills to which such materials would be relevant. The field of social work has no specific measurement criteria for each of these tasks. Social work tasks present problems because they do not remain static and usually do not exist in isolation, nor can they be divided into discrete parts and segments. Another problem recognized at the outset was that the tasks are rather nonspecific, and lead to or have a variety of interpretations. The National Technical Advisory Committee was also sensitive to this problem.

The Project staff undertook the identification of those tasks, skills and knowledges appropriate to personnel of the occupational group from the entry-level through two-year community college training program. To accomplish this, the Advisory Committee proposed to identify and select all those tasks from the function list (see Appendix B) which they felt could be adequately performed by entry-level workers in social service, as follows:

Level I: Entry level through high school equivalency programs.

Level II: Post-secondary through Associate degree programs.

An additional level, Level III, was added at the request of technical consultants who felt that some of the essential tasks required training beyond the two-year college program. Actually, only those tasks appropriate to the first two levels needed to be identified; the others would be considered automatically as being above these levels of training.

The results of the grading were analyzed by two categories: level of training and respondent group. The respondents were divided into three groups: (1) six social workers from the National Technical Advisory Committee; (2) six non-social workers from the NTAC; and (3) six local social work consultants. The backgrounds of the individuals involved were quite varied but all shared common interest in a concern about social work. Of the six in Group 2, four were physicians, one was a medical care administrator, and one was working in manpower research.

The social workers in Groups 1 and 3 also brought with them their own specialty areas. Of the twelve, five were medical social workers employed in hospital settings, three were educators teaching in graduate schools of social work, two were in public health, and two were in psychiatric services. Among these respondents, some had teaching positions in addition to their administrative functions or professional practices.

In general, there was wide variation in the ratings assigned to many of the items. In addition, not every respondent rated every item. On a few items, there was between 75 percent and 100 percent agreement among the groups as to training level. There were 40 tasks rated by all groups as Level I, and three tasks as Level II.

TABLE 1

Summary of Ratings of All Tasks
by Respondent Group

	Number of Tasks Rated, by Respondent Group					
	Group 1		Group 2		Group 3	
Level of Task	Number of Tasks Rated	%	Number of Tasks Rated	%	Number of Tasks Rated	%
I	107	.55	109	.56	78	.41
II	60	.31	68	.35	67	.36
III	28	.14	17	.09	44	.23
Total	195	100%	194	100%	189	100%

One of the factors affecting the grading of the tasks was the language in which they were expressed. The vagueness and lack of specificity of the tasks left them open to a variety of interpretations which affected assessment of difficulty and complexity, and, therefore, level of performance or training.

The tasks were further evaluated and rated as to criticality, cognitive level (difficulty), and degree of human interaction involved. The criticality scale was used to assess the level of risk which can be allowed in the performance of each task without a significant loss of time, materials, equipment, patient comfort, or safety. The scale for cognitive level was used to evaluate the depth of knowledge necessary to perform the task well. The human interaction scale was used to assess the level of human interaction skills in which the performer deals with recipients or respondents to the service or activity offered. For a detailed definition of the five-point scale developed for each of these categories, see Appendix C.

A selected group of seven social workers was invited to evaluate each task according to the scales. The backgrounds of the seven workers were: two from a psychiatric clinic, three from community mental health, one instructor from a graduate school of social work, and one medical social worker.

The results of this analysis showed variations in assigning scale values. The range and mode score for each task were evaluated. A scan through the rank scores showed some close agreements among the respondents. A closer study and analysis might contribute to development of a more accurate instrument for task analysis in social work. These data, limited though they may be, will also provide a basis for comparison with the forthcoming survey data.

For practical interest, the tasks previously selected by the committee and panel as Levels I and II were examined for their ratings on criticality and cognitive level. (See Table 2.) There is a surprisingly close relationship between Levels I and II tasks and their ratings on the criticality and cognitive level scales. Level I tasks were rated lower on both scales and Level II tasks were generally rated higher. There were some tasks where large differences were observed in the respondents' ratings. This might have been caused by the inadequacies of the language of the task as well as the lack of similar experience among the respondents. They were, therefore, unable to arrive at equal judgments, and this fact might have contributed to the differences of opinion.

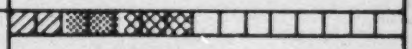
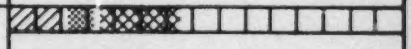
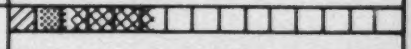
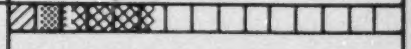
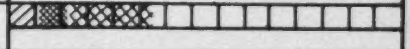
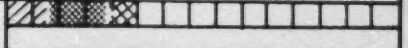
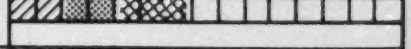
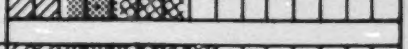
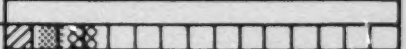
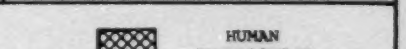
The ratings by the panel of seven experts on task dimensions of criticality, cognitive level, and human interaction were compared with the tasks rated as Level I (entry) by the National Technical Advisory Committee and the selected panel of social workers. Although insufficient data limited the use of statistical techniques in deriving significant conclusions, this comparison was made to find out whether there was agreement in the total evaluations of these tasks (Level I). It was assumed that entry-level tasks are less critical in nature and less difficult to learn and perform. These two elements were adjudged necessary and appropriate to the education and training potential of the entry-level worker.

Each task was reviewed on each dimensional scale to find out the range of the responses of the panel of experts. Analyses of the criticality ratings showed that of the 46 Level I tasks, 15 tasks had a range of 1 to 2; 21 tasks showed a range of 1 to 3, and one task had a range of 2 to 3. Nine tasks obtained a rating of 4 in at least one instance. The mode scores found in these nine tasks were 1, 2, or 3, with the exception of one (Task #25 of Table 2, page 8) which showed a wider spread of responses.

TABLE 2

COMPARISON OF LEVEL I AND LEVEL II TASKS AND THEIR
RATINGS ON CRITICALITY, COGNITIVE LEVEL, AND HUMAN INTERACTION

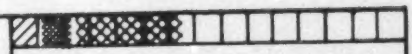
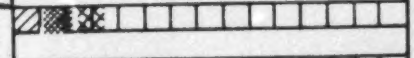
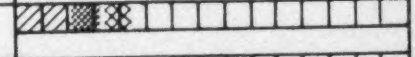
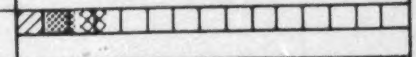
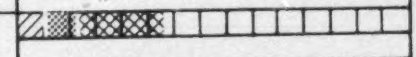
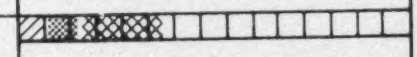
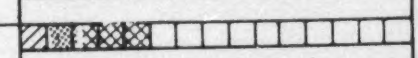
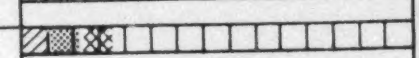
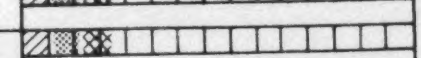
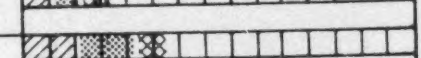
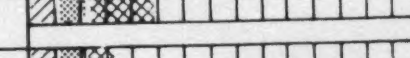
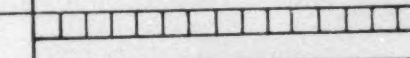
LEVEL I

1. Explain the nature of agency services available.	
2. Explain and interpret eligibility requirements (e.g., age, citizenship, financial, certain groups or status) of the program or agency.	
3. Take initial application for service.	
4. Assist clients in application procedures.	
5. Help clients fill out forms.	
6. Help clients obtain necessary records, documents required (i.e., birth certificate, financial statement).	
7. Locate neighborhood social, recreational, or educational resources.	
8. Acquaint patients with available community resources and assist them in using these resources.	
9. Answer inquiries from individuals and agencies regarding available medical services and eligibility.	
10. Provide information to individuals and groups regarding existing community resources such as public assistance, health services, legal aid, etc.	
11. Make referral either by phone, letter or personal contact, arranging date, time, place, and person for the patients.	
12. Refer patient to sources for correction of defects in dress, personal hygiene, grooming.	
13. Refer patient to appropriate recreational, social and hobby resources.	
14. Provide concrete service to patient or his family by providing counseling on information and referral to community resources (recreational, social, bargain places, etc.)	
15. Provide concrete service to patient or his family by counseling on babysitting services.	
16. Provide concrete service to patient or his family by counseling on finding a home.	
17. Assist patient in adjusting to new or present housing situation.	
18. Help patient/family plan and prepare moving to a new neighborhood.	
19. Help patient or family adjust to present neighborhood.	
20. Make requests for car fare.	
21. Provide social and recreational experiences to patients through individual contacts or activities.	
22. Provide social and recreational experiences to patients through small group activities (games, picnics, developing newspaper in hospital, etc.)	
23. Make home visit to gather routine information.	
24. Assist in facilitating communication between the agency and the community by clarifying agency programs to individuals.	
25. Assist in facilitating communication between the agency and the community by conveying community cultural patterns and attitudes to agency professional staff.	
26. Act as an interpreter where language is a barrier.	
27. Maintain patient contact with the community by encouraging relative to communicate patient's adjustment during or after home visits.	
28. Maintain patient contact with the community by encouraging patients to communicate problems while on leave from the hospital.	

CRITICALITY COGNITIVE HUMAN INTERACTION

Maximum score, each component, 5; total, 15.

TABLE 2 (Continued)

29. Provide social-recreational activities to patients and/or children in the waiting room.	
30. Report observation and assessment of patients and families to the therapist or supervisor.	
31. Arrange transportation and travel for patients.	
32. Provide transportation for patients to clinics, hospitals, etc.	
33. Secure necessary documents for patients - passports, visas, health, birth, marriage, etc., records.	
34. Arrange clinic and other appointments for patients.	
35. Escort patients to clinic, hospital, etc.	
36. Provide escort service to patients such as the use of volunteers.	
37. Make phone calls or home calls to check a failed appointment.	
38. Read and/or write letters for patients unable to read or write.	
39. Send notice or form letters regarding failed appointments and give new appointments.	
40. Secure appliances for patients.	
41. Obtain specific information from patients' charts as requested by social worker, nurse, etc.	
42. Provide babysitting and other child care services for patients.	
43. Provide hospitality service for visitors and conduct tours of agency facilities.	
44. (Routine clerical procedures essential in facilitating patient services) Filling out forms.	
45. Routine phone calls.	
46. Securing patients' charts.	
LEVEL II	
1. Help prepare patients for treatment by discussing observation with patient and clarifying and interpreting patient's confusion, anxieties, etc.	
2. Help families/patients cope with illness by interpreting, clarifying their illness, and enabling them to ventilate fears, anxieties, concerns.	
3. Provide support and help patient evolve better ways of adjusting to the reality situation.	

CRITICALITY COGNITIVE HUMAN INTERACTION

Maximum score, each component, 5; total, 15.

Task #25, "Assist in facilitating communication between the agency and the community by conveying community cultural patterns and attitudes to agency professional staff," was consistently rated higher on all three dimensions of the survey. Various interpretations might be made from the vague language in which this task was stated. There are several levels of expertise capable of facilitating communication between the agency and the community. Cultural patterns and attitudes can be brought to the attention of agency (professional) staff by many sources, i.e., clients, indigenous workers, community leaders, and other professionals knowledgeable in the field.

A similar review of the cognitive scale showed these findings: 24 tasks had a range of 1 to 3; of these, five tasks showed a smaller range of 2 to 3. Nine tasks had a range of 1 to 2 and one of these nine had a single rating of 2. Six tasks were also rated 1 exclusively. Two tasks had a range of 1 to 4; and five showed a range of 2 to 4, narrowing the variation of the responses.

Mode scores found in this cognitive dimension for all tasks were moderate or average with the exception of Tasks #22 and #25 which were given a somewhat higher difficulty score. Task #22, "Provide social, recreational experience to patients through small group activities (games, picnics, developing newspaper in hospital, etc.)" may be perceived by the respondent at one level as requiring planning and organizing skills, or at another level could be interpreted as the carrying out or maintenance of a program already developed.

In other words, Task #22 might have been interpreted in reference to a stage in the process of performance, e.g., the development of ideas and planning for implementation of a program, versus implementing an organized and well-developed program. However, Task #25 might reflect respondent judgments on levels of involvement and quality of expertise required in the performance of this task. As mentioned above, knowledgeable professionals could "facilitate communication by conveying cultural patterns and attitudes to agency staff," as is often done in special training workshops or orientation. Equally competent to do this task with a different type of expertise and for different staff needs might be a client or indigenous worker who could also inform agency staff about the community's cultural patterns and attitudes in various types of informal interaction regarding a particular patient or group behavior.

These differences provide a useful tool in the analysis of concepts and skills in organizing the content and sequences of instruction. They also highlight areas of ambiguity in the analysis of tasks in social service. It is anticipated that criteria which define the educational dimension of the task might be developed from which social service tasks could be objectively and explicitly defined and specified. This would minimize the ambiguity of the task analysis.

The tasks on the inventory list were not categorized. This was done deliberately because at the first attempt to rate the tasks, the Social Service Committee felt that categorical headings (intake, supportive, community, referral and administration) tended to bias their ratings and might also influence the respondent in the survey. Level I tasks were

grouped according to functional categories. Seven categories were identified as a result of the grouping.

I. Courtesy and information services. These include tasks related to giving and explaining of information and similar services which are generally considered non-treatment or indirect services.

II. Obtaining information. Tasks that are considered specifically related to information gathering.

III. Referral making. Tasks normally performed in making referrals.

IV. Assistance with agency procedures. Tasks that are considered as providing direct service to patients which are essential to agency structure, organization, policy, and requirements.

V. Counseling and direct services. Those tasks performed in providing direct assistance to patients in services specifically related to their treatment or to their social health.

VI. Transportation and escort services. These include all tasks related to the transporting and escorting of patients for services related to treatment plans.

VII. Advocacy and facilitative services. Tasks related to facilitating service by assuming an advocate role on behalf of patients' needs. (For detailed listing of tasks, see Appendix D.)

After the tasks had been sorted into functional groups, analysis showed that there was substantial agreement among the panel in rating the tasks within each group. In addition, their rankings of each group on the three dimensions of criticality, cognitive level and human interaction also were consistent. Table 3 gives a summary of these rankings in order of low to high for each dimension. This showed the rank order in each dimensional category for each functional group, and the overall rank for all dimensional categories for each group of functions.

Of most interest to the Project staff was the degree of similarity found in the ratings of Level I tasks among the respondents. The evaluation of the panel on the criticality, cognitive level and human interaction dimensions of these tasks generally confirmed the assessment of the National Technical Advisory Committee on the training level of these same tasks. These indications of agreement provided the Project staff with confidence as to the validity of such evaluations. However, closer scrutiny by categories revealed some differences within the classified groups.

Among those tasks classified in Groups, I, III, VI, and VII, there appeared to be no significant difference in rankings for criticality. However, Task #3 in Group II was perceived as being highly critical, while Tasks #7 and #8 in Group V were rated less strictly than the rest of the tasks in that grouping.

TABLE 3

RANKING OF FUNCTIONAL GROUPS ON SCALES OF CRITICALITY, COGNITIVE LEVEL, AND HUMAN INTERACTION, AS RATED BY PANEL OF EXPERTS

Functional Groups	Rank Order by Components			Overall Rank
	Criticality	Cognitive	Human Interaction	
I. Courtesy and Information Services (6 tasks)	4	4	4	4
II. Obtaining Information (6 tasks)	5	3	3	3
III. Referral Making (3 tasks)	3	5	5	5
IV. Assistance and Agency Procedures (9 tasks)	2	1	1	1
V. Counseling and Direct Services (13 tasks)	6	7	6	6
VI. Transportation and Escorting Services (4 tasks)	1	2	2	2
VII. Advocacy and Facilitative Tasks (2 tasks)	7	6	7	7

On the cognitive scale, Groups III, IV, VI and VII were rated with consistency, while Groups I, II and V showed larger differences. These observations are based on a review of individual task difficulty which is highlighted by the difference in points between the higest rated task and the lowest. Once again, the significance of these differences cannot be firmly nor clearly established. The level of acceptance on any of these dimensions has not yet been specified by the Project staff. The analysis of this investigation may provide the Committee with some information that can be applied toward the recommendation of tasks appropriate for entry-level workers in social service.

A detailed analysis was not required in the area of human interaction. The evaluations of the experts on this scale would be used for assessing the content required in the development of curriculum for human behavior and interpersonal knowledge and skills. It is interesting to note that the rank order of the groups on this dimension appear to parallel the rank order of

the groups on the other two dimensions. This may indicate possibilities for sequencing units of instruction (knowledge and skills) according to functional categories, starting with simple concepts and progressing to more complex concepts while at the same time appropriately interlacing all of the instructional units.

B. Tentative Findings and Recommendations

A significant finding in this analysis was the similarity between the evaluations of a group of social service tasks by the National Technical Advisory Committee and those of the panel of experts. Both groups rated each task of the social service function list provided by the Project under separate criteria, in different situations. This agreement was verified by the correlation between the evaluations of the groups on the level of training (entry) for the tasks in this particular group, and the perceived levels of criticality, cognitive level and human interaction. In other words, those tasks believed to be suitable for training entry-level workers, as evaluated by the Technical Advisory Committee, were also felt by the panel of experts to require less intensity in the task dimensions of criticality, cognitive level and human interaction.

This analysis provided the Project staff with data related to particular functional categories and specific tasks which were evaluated as being within the capabilities of entry workers in social service and within the feasibility of training programs for such level. These data should enable the Project to define appropriate functions for entry workers and training needed to learn those functions. However, these data by themselves were not sufficient for the purposes of instructional development.

In order to proceed toward preparing and developing instructional materials, several items had to be defined. These items would include job description, functional roles and responsibilities, and from these, educational requirements and other personnel qualifications or characteristics necessary for the specific position. The Project is primarily concerned with those tasks associated with entry levels of allied health occupations. In social service, the pre-baccalaureate position has not been clearly formulated nor standardized. It was necessary, therefore, to develop a definition to provide the Project with a framework for the preparation of instructional materials.

Two subcommittees of the National Technical Advisory Committee were established; one was to examine ways of differentiating and delineating tasks for entry-level and two-year college workers, and the other, to define the knowledges, skills and attributes of those tasks.

The first subcommittee decided in the context of the limits of the Project that it was unable to solve satisfactorily the complex problems of task differentiation in the social services, nor could available survey or study data give the full answer. Another problem was that of deciding on what plan tasks should be divided: whether on the basis of visible activity, purpose of the task, the area of the activity, or its depth and/or quality.

These concerns were legitimate and could not easily be ignored. As a practical solution to this problem, however, analysis of the current utilization of

pre-baccalaureate workers and the types of tasks and functions assigned to them was used to formulate a tentative job description and task assignment.

1. Suggested Job Definition and Task Assignment

A list of tasks was assembled from a survey of job descriptions of community health workers, mental health workers, and other related indigenous aides. In addition, a random sample of four social service aides and three mental health aides in Los Angeles was interviewed. They were asked what types of tasks they do as regular components of their jobs, and which tasks they found most difficult. These findings, with recommendations and suggestions from the Advisory Committee and panel of experts, led to the following definition of the entry social service worker in health:

> The SOCIAL SERVICE HEALTH WORKER (entry and Associate degree level) is a pre-baccalaureate worker who may be employed in a community health, mental health, or other medical care facility to provide services to patients in their homes, in the agency, or in the community. Major functions of the social service worker are to bridge the gaps in services among health professionals and the gaps between consumers' needs and the service delivery programs. Such functions will include casefinding and bringing the community population in closer communication and participation with the agency programs; acting as resource mobilizer and expediter by locating and effectively using community resources; providing feedback to the agency about barriers and needs for services in the agency or the community; negotiating the system; teaching and "coaching" patients on social, emotional, and health-related problems; and functioning as case monitor and client advocate. Depending on agency or local needs and policies, the social service worker may provide counseling and other therapeutic services to families, groups, and individuals with specific health-related problems.

The definition is an amalgamation of typical and perceived functions of the community worker or allied health worker as he is now being trained and used in a variety of health and mental health service programs throughout the country. It constitutes a formulation of the progressive attitudes toward the innovative use of allied health personnel.

This definition, and the following task assignments, provided a framework or baseline from which assessment could be made of the training and educational needs of this entry worker.

Suggested Task Assignments: Basic Functions

1. Obtain client's personal and social information as required by agency standards for client's case record or as assigned by the supervisor.

2. Obtain routine information from clients or on behalf of clients as assigned by the supervisor.

3. Maintain client contact by making home calls to find out how the client is doing or why he failed an appointment. Report information to the supervisor or refer client to appropriate agency if indicated.

4. Provide supportive therapy to clients and their families under the direction of a supervisor.

5. Write reports and letters of referral on behalf of client's medical, financial, or other needs.

6. Help clients with problems of personal or family management which may be complicated by problems of alcoholism, drug use, or illness.

7. Help parents with problems of child care management such as inadequate supervision, care, or discipline.

8. Locate community resources.

9. Establish and maintain relationships with other social and resource agencies in the community.

10. Record and report case histories or summaries.

11. Escort and transport clients when necessary.

12. Help clients with a variety of social, legal, and financial problems by assuming an advocacy role.

13. Maintain role of case monitor by acting as a listening post in community or hospital setting and obtain vital information about client's whereabouts, problems, and needs not known to the agency.

14. Identify sources of problems in the community and report to the agency.

The second subcommittee was in close agreement as to the role and function of the entry-level worker suggested by the first subcommittee. In fact, it was this kind of cooperative thinking that made possible the smooth progress of the Project's activities in this field.

A significant finding in the preliminary investigations was the age range and life experience among currently employed health and social service aides. For the most part they had been selected from low-income groups, many having had limited education and work experience; many have been recipients of some type of social service. Their educational needs will be quite different from those of the recruits who went through the usual educational route and who have never received welfare, probation or other social services. The positive qualities of low-income, former social service recipient workers should be recognized; training and curricula should be developed to enhance and promote those qualities that will insure their effective contribution in the job setting. Furthermore, reorganization of services and training of professionals and staff in the use of and cooperative work with pre-professionals are also necessary to promote their effective integration into the service delivery system. Some form of in-service training program is essential for both aides and professionals.

2. Proposed Curriculum for Entry-Level Workers

Staff review of training programs and guides for aides has revealed much similarity of content. There also seems to be recognition of the kinds of value that aides have to offer. In terms of life-style and personal qualities, they represent a new approach to service delivery. The current thinking of the Project staff is to develop a generic approach to the training of the entry worker in social services for the health field. Some content areas are seen as necessary to the education of social service personnel on all levels, namely, content on behavior, content on policy or systems, and content on interventive methods. Furthermore, there are certain basic skills in verbal and written communication, interpersonal relations and linking clients to services. How far each level could go with the educational content in those areas would ultimately be determined by the students and the faculty at that level.

The two subcommittees of the Social Service Technical Advisory Committee, in addition to outlining the tasks and functions of the entry-level worker, recommended the following skills and knowledges which would enable the community worker to function effectively as a health-service facilitator. These attributes are considered essential to helping patients and their families in the continuing process of obtaining health care. Furthermore, they have been determined by observing the processes involved in the satisfactory accomplishment of some of the major tasks in social service.

1) Health-related problems of individuals and the community.

2) Community resources for treatment of or intervention in health problems.

3) The health care delivery systems in the community which are charged with the health care of people.

4) Skills and know-how in facilitating provision of services to people and channeling people into the systems of health and welfare.

5) Skills in interviewing and interpersonal relations; ability to make verbal and written reports.

6) Human behavior and the processes of growth.

7) Social, cultural, and behavioral aspects of health and illness.

Reading and writing ability at least at sixth-grade level is recommended for the entry-level worker (aide). Through remedial work and continuous training and education, it should ultimately be possible for an aide to attain college level programs. In addition to learning ability and because of the nature of this work, the social service worker needs to have certain personal qualities and attitudes. He should have a good verbal skill, attentiveness, patience, and a willingness to help by listening and offering support. He needs an outgoing personality and must have respect for himself and others. He must be sensitive and flexible, but objective in assessing client needs.

Another suggestion for the training and utilization of the entry social health or community health worker is for some basic nursing skills, such as the American Red Cross. This worker is primarily involved in bringing health services into the homes of patients. For this reason it is felt that the community health worker should have some basic skill in nursing care services, such as taking vital signs and observing signs and symptoms of the patient's condition. This skill will provide continuity of care for patients and an effective and productive use of community health workers who often are confronted in the field with situations requiring some knowledge of illnesses and what to do with them. It will also enhance their abilities to provide services to patients in the home. For example, when a community health worker makes a home visit to find out whether a patient is adjusting after an illness, he could perform some nursing services under the direction of a nurse, such as taking the patient's temperature and blood pressure.

These ideas are representative of the thinking and findings of the Project staff. The fact that they are tentative has not kept the Project from moving into the next step, which is curriculum development. Based on these formulations, the Project staff is in the process of developing two items of instructional material--one on fundamentals of communication for the entry-level worker in allied health, and the other a basic but comprehensive unit on health and mental health content for social service workers. The need for these training materials is quite clear despite lack of documentation from our yet uncompleted national survey. The need has been identified from the lack of relevant instructional materials in the field and from the expressed concerns of workers and educators.

C. A Career Lattice Concept for Entry Workers

A major interest of the Allied Health Professions Projects is the identification of core concepts and skills among the various health occupations. It is an assumption of the Project staff that the allied health occupations share many common skills and knowledges. These common skills can be identified through an analysis of tasks and functions performed by workers in the various allied health occupations. It is anticipated that the surveys of the occupations will produce data to validate this assumption.

The use of task analysis (breaking a single task into a series of identifiable steps and key points) helps to reveal those underlying skills and concepts that are important to the learning or performance of that task. Skilled professionals and teachers often are unaware of these small important key points, having lost touch with the learning needs and the insecurity of the novice practitioner. This type of task analysis also is important in identifying common skills and concepts that may be found in several occupations. This group of skills and concepts can then be translated into a core curriculum in allied health. Once all areas of skills and concepts have been identified, it is possible that several "cores" may result. Such findings can be of tremendous value in the development of a comprehensive and systematic curriculum for the allied health occupations.

To demonstrate this point further, a conceptual model for a career "lattice" for the entry-level social service worker in a health setting is given in

Figure 1.* The model is broadly conceived and is not limited to health entry workers.

The model presents jobs related to areas of direct patient care services. It illustrates parallel levels of occupational and educational requirements, with multiple opportunities for career choices. It is generally accepted that no decision regarding specialization in an occupation should be made during the initial phases of one's career development, but that one should acquire a salable skill which can easily be transferred to a different job. People are not always well-advised in their career choices; moreover, unanticipated circumstances, such as money problems, illness, etc., may force them to alter their choices. A person should have sufficient skill and job satisfaction at any stage of his career to be able to make decisions regarding his career choice. He also should be aware of the opportunities and demands of other jobs for which he may be qualified so that he can be prepared to meet them. The system of hiring and training people should provide logical opportunities for job mobility wherever possible.

This conceptual model (Figure 1) also serves to illustrate the emerging levels of personnel utilization in social work practice from the pre-college level workers (aides) through the graduate professional workers (M.S.W.'s). From the training and curriculum aspects, this lattice also illustrates the potentials for teaching common skills and knowledge appropriate to the occupational titles at each stage of the educational continuum, or in the form of in-service training.

One of the aims of the Allied Health Professions Projects is to develop instructional materials related to specific performance objectives drawn from the analysis of tasks performed by individuals in an occupational group. If tasks can be identified for each level of the social service educational continuum, curricula could then be developed which would offer a logical sequence of content and skills. This would minimize duplication of training at all levels and provide a cumulative system for educational up-grading and career advancement. The extent to which the Project staff can identify the tasks performed and the educational needs of the entry-level social service worker in the health field should be an invaluable contribution to professional practice and training.

V. CONCLUSIONS

This report is a summary of developments made between January 1969 and March 1970 in the social service occupational grouping of the Allied Health Professions Projects. The major objectives of the Projects are to analyze job practices and potentials in those allied health occupations undertaken by the Projects and to develop instructional materials required to teach job skills. These objectives were to be accomplished with the help of skilled committees

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* The term "lattice" is used rather than the more familiar concept of the ladder to emphasize the interlocking nature of the skills and knowledges involved, and to suggest the possibility of horizontal as well as vertical mobility for the worker who enters the field.

FIGURE 1

CONCEPTUAL MODEL FOR CAREER LATTICE

SOCIAL SERVICE OCCUPATIONS IN HEALTH

Community Health Services	Hospital and ECF	Other Fields of Social Work	Alternate Professions	EDUCATIONAL CONTINUUM
Consultant Supervisor Administrator	Consultant Supervisor Administrator	Consultant Supervisor Administrator	Health Educator Rehab. Counselor Public Health Nurse Medical Care Adm. Hospital Adm.	Graduate
Public Health Social Worker Psychiatric Social Worker	Medical Social Worker Psychiatric Social Worker	Child Welfare Worker Family Assistance Community Organization	Physician Dentist Psychologist Lawyer	
P.H. Social Work Asst. or Comm. Mental Health Asst.	Medical Social Work Asst. Mental Health Assoc.	Social Worker Public Assistance Community Service Program	Registered Nurse (B.S.) O.T.R. Reg. Phys. Therapist Dental Hygienist	Baccalaureate Degree
Community Health or Community Mental Health Worker	Medical Social Service or Mental Health Aide	Social Service Worker Welfare Assistant Child Development Worker	LVN/LPN/RN (AS) C.O.T.A. Physical Therapist Assistant	Associate Degree
Community Health or Comm. Mental Health Aide	Medical Social Service or Mental Health Worker	Homemaker Child Care Aides	Nurses Aide Physical Therapist Aide Office Asst. Admitting Clerk	High School or Less

who assisted the Project in establishing levels of training and determining the curricula for such training and education. The results of the social service survey currently being conducted in selected health facilities throughout the country will validate or modify the decisions of the Committees and the Project staff.

Within the field of social services, it was necessary to define the roles and functions of entry-level workers (aides and Associate degree positions) so that the Project personnel could then define its own focus and scope in this occupational area. The lack of criteria in the field on which to base such definitions left this responsibility largely to the expert recommendation of the National Technical Advisory Committee for the Social Service Occupations. In addition to the definition and role assignments of this entry level, there was need to determine and establish training and educational requirements that would be commensurate with those roles and functions. In both of these responsibilities, the National Technical Advisory Committee has been extremely supportive and contributive.

This report, therefore, has summarized preliminary findings and developments in the Project as a result of two Technical Advisory Committee meetings, subcommittee meetings, and staff activities. These preliminary findings are important because they provide a framework for initial Project objectives in the preparation of instructional materials. The intention of the Project is to develop curricula to meet the needs of the field as defined by a task analysis. Thus, these findings are tentative and will be modified by outcomes of the national survey.*

The discovery of who does what in social service in terms of specific tasks or services will be a significant contribution to the profession of social work, which long has been struggling with the question of task delineation and differentiation. In terms of patient care services in hospitals and other health programs, there is a need to determine what services are being provided. Are the services in keeping with the current concept of the function of social service in hospitals and health care programs? Are they designed to facilitate treatment and service by providing social information related to illness? Do they provide families with needed services from community resources to promote health and welfare? Do they offer social and emotional support to patients and their families in times of illness, which is as important as physician care and treatment at such a time?

Who provides the services also is important. How tasks are assigned and who has the responsibility for what functions will provide significant information related to the structure of social service delivery in health care.

Such information is invaluable in the development of a practical method of structuring training and educational programs and preparing appropriate content that will be relevant and meaningful to the participants. It is anticipated that answers to these questions will be provided by response to the national survey.

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* Due to the scarcity of social service workers in many of the hospitals in the national survey list, selected health facilities have been added for the social service survey. (See Appendix E.) The survey should be completed during the summer of 1970.

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6/26/70

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APPENDIX A

NATIONAL TECHNICAL ADVISORY COMMITTEE

FOR SOCIAL SERVICE OCCUPATIONS

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APPENDIX A
(continued)

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Kay Dea

Charles Roberts

Esther Spencer

APPENDIX B

SOCIAL SERVICE OCCUPATIONS FUNCTION LIST

		Page
I.	Intake Services	28
II.	Information and Referral Services	29
III.	Treatment Services	30
IV.	Supportive Services	33
V.	Community Services	34
VI.	Administrative Services	36

SOCIAL SERVICE OCCUPATIONS

Function List

INTAKE SERVICES

1. Intake interviewing (clarification of services to prospective patients and determining if services are consonant with the needs of the patients).

   a. Help client define problems and needs for service.

   b. Assess client's request or need for service.

   c. Decide whether client's request or need is appropriate for services rendered.

   d. Explain the nature of services available.

   e. Explain and interpret eligibility requirements (e.g., age, citizenship, financial, certain groups or status).

   f. Take initial application for service.

   g. Make referral to appropriate agency.*

   h. Assist clients in application procedures.

   i. Help clients fill out forms.

   j. Help clients obtain necessary records, documents required (e.g., birth certificate, financial statement).

   k. Help clients develop or use personal resources.

2. Preparation of patients for treatment, dealing with resistance to treatment, and establishing the proper motivation for treatment.

   a. Define goals for treatment.

   b. Explain the treatment process.

   c. Observe patients' reactions.

   d. Discuss observations with patient and clarify and interpret patients' confusion, anxieties, etc.

   e. Discuss limits and requirements of treatment.

---

* Referral process - separate list, below.

f. Identify the nature of resistance.

g. Evaluate nature of resistance.

h. Discuss alternative to treatment.

i. Interpret the consequences of the alternatives.

j. Resolve or modify resistance to enable client to decide how to proceed.

3. Identify and assess resistance located within the agency or caused by the agency structure which may hinder clients in seeking or using agency services.

4. Communicate such findings to the agency.

5. Consult with physician and other persons involved in the care of patients where environmental manipulation of their patients is essential.

6. Provide consultation to other staff for patient problems relating to finance, health, employment, recreation, housing, exercise, companionship, and special training.

7. Act as liaison between the patient and his family, employer, teacher, etc., when it is essential to interpret patient's illness to them, to give them reassurance, or to enlist their interest and cooperation.

8. Manage parents, mate, children of patients who are being treated and who require counseling or treatment as an aid to the treatment of the patient.

INFORMATION AND REFERRAL SERVICES

1. Locate neighborhood social, recreational, or educational resources.

2. Acquaint patients with available community resources.

3. Promote the effective utilization of available community medical and social resources.

4. Answer inquiries from individuals and agencies regarding available medical services, and eligibility.

5. Provide information to individuals and groups regarding existing community resources such as public assistance, health services, legal aid, etc.

6. Answer letters of inquiry from other medical or social agencies, schools, and family regarding patients.

7. Provide courtesy and explanation services.

8. Refer patients to other agencies or programs.

a. Determine type of referral needed.

b. Determine appropriate agency for referral.

c. Explain reasons for referral.

d. Help patient understand reason for the referral.

e. Make referral either by phone, letter or personal contact, arranging date, time, place, and person for the patients.

f. Introduce patient to the referral agency.

g. Write out information on arrangement, making copy for the patient.

h. Explain to patient and help patient meet appointment, e.g.,

1) Help with transportation.

2) Arrange for babysitting service, if indicated.

3) Provide an escort.

i. Do follow-up by checking to see whether patient kept appointment.

9. Write letters of referral on patients to be discharged who need financial assistance or ongoing medical care.

10. Write letters of referral to public agencies on hospitalized patients whose families require financial assistance.

11. Make referral for financial assistance, e.g., public assistance.

12. Make referral for medical care assistance program, e.g., Crippled Children Services, MediCaid (Medi-Cal), Medicare.

13. Refer patient to legal resources in critical family or interpersonal situations.

14. Refer patient to sources for correction of defects in dress, personal hygiene, grooming.

15. Refer patient to resources for correction of remediable physical disabilities, e.g., speech therapy, vision, etc.

16. Refer patient to appropriate recreational, social, and hobby resources.

TREATMENT SERVICES

1. Clarify health problems to patient or relative.

2. Help families/patients cope with illness by interpreting, explaining their illness, and enabling them to ventilate fears, anxieties, concerns.

3. Provide support and help patient to evolve better ways of adjusting to the reality situation.

4. Provide concrete service to patient or his family by counseling on:

   a. Budget, money management.

   b. Housekeeping problems.

   c. Child care management.

   d. Information and referral to community resources (recreational, social, bargain places, etc.).

   e. Babysitting services.

   f. Finding a home.

   g. Employment problems.

5. Promote education in such matters as sexual relations, child rearing and parenthood.

6. Help in the selection of nursery school, grade school, camp, or recreational facilities for patient's children.

7. Assist patient in adjusting to new or present housing situation.

8. Help patient/family plan and prepare moving to a new neighborhood.

9. Help patient or family adjust to present neighborhood.

10. Handle children with primary disorders.

11. Assist patients or family in application to nursing homes, special schools, etc.

    a. Give patient various resource information.

    b. Help decide where need would best be met.

12. Facilitate discharge plan, expediting necessary papers, completing arrangements for follow-up, etc.

13. Make request for carfare.

14. Review patients' charts and prepare social service report.

15. Interview prospective foster homes concerning placement for patients.

16. Interview families and collaterals to obtain social information.

17. Review claims folder and other files to compile abstracts of patient information.

18. Write letters to patients' families regarding patients' progress or adjustment.

19. Discuss trial visits, financial arrangements, etc., with family of hospitalized patient.

20. Help families prepare for discharge of patient.

21. Assist clients to develop or use personal resources.

22. Arrange patient transfer from hospital to extended care facility, etc.

23. Interpret to patient's family and/or group the meaning of current or certain cultural patterns.

24. Observe gaps in values or standards between client and the community.

25. Discuss with the client the gaps or differences in values or life style between the client and the community.

26. Help client resolve conflict by accepting or adapting to differences.

27. Clarify personal standards of patient and/or family which do not conform with community standards to persons involved in the care of the patient or to the community.

28. Clarify to patients and/or families legality of certain actions, e.g., petition for admission, voluntary admission, etc.

29. Provide social and recreational experiences to patients through individual contacts or activities.

30. Provide social and recreational experiences to patients through small group activities (games, picnics, developing newspaper in hospital, etc.)

31. Make home visit to gather routine information.

32. Make home visit to observe home environment or family situation.

33. Observe behavior and appearance of clients and conditions relating to family situation.

34. Make home visit to observe and evaluate the home environment and individual or family behavior in relation to a specific problem.

35. Participate in therapy by observing and interacting with patients.

36. Participate in group therapy, family interviews or case conference.

37. Assist in facilitating communication between the agency and the community.

    a. Clarify agency programs to individuals.

    b. Convey community cultural patterns and attitudes to agency professional staff.

38. Act as an interpreter where language is a barrier.

39. Contact individuals, schools and public and private agencies for information and assistance in case planning.

40. Provide supervision of teenagers and other groups in order to correct individual or family conditions leading to delinquency or other social problems.

41. Counsel patients in relation to their financial and living arrangements.

42. Maintain patient contact with the community.

    a. Encourage relatives to communicate status of patient's adjustment during or after home visits.

    b. Encourage patients to communicate problems encountered while on leave from the hospital.

    c. Contact employers when indicated.

43. Evaluate patients for foster care or nursing homes.

    a. Explore patient's interest in placement.

    b. Determine patient's financial situation.

    c. Discuss placement plans with guardian.

    d. Complete necessary papers for placement.

    e. Help patients and relatives cope with their anxiety while awaiting placement.

    f. Keep staff informed during this period.

    g. Provide or maintain necessary follow-up care.

SUPPORTIVE SERVICES

1. Provide social-recreational activities to patients and/or children in the waiting room.

2. Observe and assess patients' behavior and appearance in activities outside the context of treatment.

3. Report such observation or assessment to the therapist or supervisor.

4. Locate nursing home vacancies, foster homes, and special education facilities (schools), residential homes for patients, tutorial and educational service for homebound, day care services, etc.

5. Arrange transportation and travel for patients.

6. Provide transportation for patients to clinics, hospitals, etc.

7. Secure necessary documents for patients - passports, visas, health, birth, marriage records, etc.

8. Arrange clinic and other appointments for patients.

9. Escort patients to clinic, hospitals, etc.

10. Provide escort service to patients, e.g., by using volunteers.

11. Make phone calls or home calls to check a failed appointment.

12. Read and/or write letters for patients unable to read or write.

13. Send notice or form letters regarding failed appointments and give new appointments.

14. Secure corrective appliances for patients.

15. Obtain specific information from patient's charts as requested by social worker, nurse, etc.

16. Provide babysitting and other child care services for patients.

17. Provide hospitality service for visitors and conduct tours of agency facilities.

COMMUNITY SERVICES

1. Assist individuals or groups in communities to recognize home, family, or community conditions contributing to problems of health, mental health or social adjustment.

2. Promote the correction of such problems:

   a. Bring to the attention of responsible community leaders such problems in the community.

   b. Stimulate awareness about the problems among groups and individuals in the community.

   c. Encourage groups and individuals to bring about change or improvements.

   d. Develop leadership and resources in the community.

3. Develop social-recreational activities for patients in clinic or hospital wards.

4. Develop and organize community volunteer groups: babysitting, escorting, transporting, etc.

5. Assist individuals or groups in the community to identify needs or gaps in services.

6. Help individuals and groups obtain their identified needs through organized community efforts.

7. Locate and develop appropriate resources within the community to meet clients' special needs for clothing, furniture, appliances, housing, etc.

8. Provide social-recreational activities to children, youth, and other peer groups in various community settings by organizing and conducting:

   a. After-school and weekend programs for young children and teenagers.

   b. Programs for older citizens in the community.

   c. Programs for young adults.

   d. Programs for parents.

9. Organize and work with small neighborhood groups or projects designed to work toward the solution of individual or community problems.

10. Develop and organize community groups concerned with the prevention of social problems such as delinquency, drug use, venereal disease, etc.

11. Provide educational services to promote health and welfare:

    a. Dental health

    b. Accident prevention

    c. Food buying and preparation

    d. Household management

    e. Consumer buying and credit

    f. Sanitation and housing problems

    g. Child care

    h. Good grooming and personal health care

12. Visit community agencies and groups to inform them of department or agency services and to become familiar with the services they offer.

13. Assist individuals and groups to organize and develop community self-help projects such as legal aid resources, child care services, community resources center, etc.

14. Coordinate the development of community resources toward the solution of problems of employment, housing, education, health, or social adjustment.

15. Disseminate information about community resources to individuals and groups in the community.

ADMINISTRATIVE SERVICES

1. Organize and handle administrative details of education projects of the clinic.

2. Interpret work of clinic to the community and secure cooperation of the community in the work of the clinic.

3. Act as liaison between clinic and community organizations which are implementing community programs related to health, welfare, and social security.

4. Initiate and maintain effective liaison with the executive level of community agencies through committee activities and leadership.

5. Participate in professional community activities for the improvement of social services.

6. Plan and organize social services to patient groups in clinic or hospital.

7. Plan, assign, and supervise the work of subordinate workers.

8. Review social service participation in various programs to determine whether services and programs are meeting patient needs.

9. Note strengths, lags, and gaps in service.

10. Consult with program staff, hospital and medical administration regarding methods for improving services where needed.

11. Define areas needing additional personnel and describe level of personnel required.

12. Outline objectives of the facility and relate policy and procedures of social service department.

13. Confer with medical, paramedical, and other personnel to interpret social service function as related to specific cases.

14. Provide social casework services to individuals and groups and share in decisions affecting the policy of the total program which involve an interdisciplinary team.

15. Direct the admission staff in case screening and determination of eligibility of patients or applicants for medical care.

16. Make decisions on difficult borderline cases.

17. Supervise and consult with social work staff regarding casework practice and policy decisions.

18. Review case records for accuracy, completeness, and conformance to policies.

19. Schedule regular conferences with workers and give emergency consultation.

20. Conduct periodic evaluation conferences with workers and prepare written evaluation reports.

21. Participate in planning the curriculum and provide the orientation and training of new staff.

22. Develop program of staff education and development.

23. Orient new workers to casework practice in a medical setting.

24. Recruit, hire, and fire social service personnel.

25. Evaluate performance and recommend salary increments in written reports.

26. Participate in intra-hospital committee activities.

27. Support efforts toward improvement of intra-departmental programming.

28. Attend professional conferences; present papers.

29. Participate in necessary research and formulate methods of applying data obtained.

30. Gather and compile ethnic and demographic data for use in program development.

31. Gather information:

    a. Gather selected information on certain groups of patients (e.g., chronic illness) to assist in determining needs for planning for service.

    b. Gather and compile lists of community resources.

    c. Gather and compile physician lists which provide specific medical resources - will take patients on medical or time-payment arrangement, etc.

32. Perform routine clerical procedures essential in facilitating patient services:

    a. Fill out forms.

    b. Make routine phone calls.

    c. Secure patients' charts.

33. Prepare monthly department statistics.

APPENDIX C

DEFINITIONS OF RATING SCALES

Three scales were developed by the Allied Health Professions Projects to assess the Criticality, Cognitive Level and Human Interaction of the various tasks and functions of each occupational area. This section gives the definitions of these scales. Scale ratings for Level I and Level II tasks appear in Table 2.

I. CRITICALITY

This scale is used to assess the level of risk which can be allowed in the performance of each task without a significant loss of time, materials, equipment, patient comfort, or safety.

1. Flexible: Relatively unimportant whether the task is done a certain way or not. Example: Reading to patients.
2. Moderate: Normally done within tolerance. Example: Interviewing to obtain social information.
3. Average Reversible: Deviation from prescribed methods could result in minor delays or loss of resources. Example: Referring patients to social agencies.
4. Above Average: Very little tolerance may be allowed without risk to worker or patient. Example: Make decisions in borderline cases.
5. Irreversible: Highly critical--must be done within strict parameters to avoid irreversible loss of health or human resources. Example: Interviewing an emotionally disturbed suicidal patient.

II. COGNITIVE LEVEL

This scale is used to evaluate the depth of knowledge necessary to perform the task well.

1. Routine Procedure: Requires recognition of facts in performing simple procedures. Example: Obtaining routine information for application forms.
2. Several Procedures With Minor Decisions: Requires interpretation and recall of information to perform a series of procedures to complete a task. Example: Interpreting eligibility requirements.
3. Select Most Suitable Procedures: Requires the ability to solve new problems with a minimum of direction based on past experiences with similar situations. Example: Referring patients to resource agencies.
4. Establish and/or Modify Procedures: Requires analysis of a situation or problem and the formulation of the most suitable procedure for solution. Example: Identifying approaches and solutions to patient needs and problems.
5. Making Complex Decisions With Little Precedent: Requires the ability to develop new methods of treatment. Example: Devising psychosocial treatment.

III. HUMAN INTERACTION

This scale is used to assess the level of human interaction skills in which the performer deals with re 'pients or respondents to the service or activity of the performer.

1. No Human Interaction: Requires no human interaction with patients or personnel. Example: Locating social, recreational, educational medical resources.
2. Routine Impersonal Interaction: Requires performer to exchange impersonal information, perform impersonal services. Example: Secure necessary documents for patients.
3. Routine Personal Interaction: Requires performer to engage in personal interaction in performance of impersonal service. Example: Assisting clients in application procedures.
4. Personal Interaction: Requires performer to interact with recipients in personal manner to assess, instruct, persuade, or perform personal service. Example: Providing support and helping patients to evolve better ways of adjusting to reality situation.
5. Highly Personal Interaction: Requires performer to interact with recipients or respondents to bring about changes in behavior. Example: Helping families or patients cope with illness by interpreting and clarifying the illness and enabling them to ventilate fears, anxieties, and concerns.

APPENDIX D

CATEGORIZATION OF LEVEL I TASKS

The social service functions which had been defined by the National Technical Advisory Committee and panel of selected social workers as Level I or entry-level tasks have been classified into seven functional groups, as follows:

I. Courtesy and Information Services

1. Explain agency services. (1)*
2. Explain and interpret eligibility requirements of the program or agency. (2)
3. Answer inquiries from individuals and agencies regarding available medical services and eligibility. (9)
4. Provide information to individuals and groups regarding existing community resources such as public assistance, health services, legal aid, etc. (10)
5. Provide concrete services to patients or their families by providing information and referral to community resources. (14)
6. Provide hospitality service for visitors and conduct tours of agency facilities. (43)

II. Obtaining Information

1. Make home visit to obtain routine information. (23)
2. Make phone calls or home calls to check a failed appointment. (37)
3. Make verbal or written reports of observations or information obtained from patients or families to supervisor or person in charge of patient's treatment. (30)
4. Secure necessary documents for patients, e.g., passports, health record, birth/marriage certificate. (33)
5. Obtain specific information from patient's chart as requested by social worker, nurse, therapist. (41)
6. Locate neighborhood social, recreational or educational resources. (7)

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*Number designation of task as listed in Table 2, Page 8.

III. Referral

1. Make referral for services needed, either by phone, letter or personal contact, arranging date, time, place, and person for the patient. (11)*

2. Refer patient to sources for correction of defects in dress, personal hygiene, grooming. (12)

3. Refer patient to appropriate recreational, social and hobby resources. (13)

IV. Assistance with Agency Procedures

1. Take initial application for service. (3)

2. Assist clients in application procedures. (4)

3. Help clients fill out forms. (5)

4. Help clients obtain necessary records, documents required. (6)

5. Make request for carfare. (2)

6. Send notices or form letters regarding failed appointments and give new appointments. (39)

7. Secure appliances for patients. (40)

8. Perform routine tasks essential in facilitating patient services, e.g., filling out forms, routine phone calls, securing patient's charts. (44, 45, and 46)

9. Arrange clinic and other appointments for patients. (34)

V. Counseling and Direct Service

1. Coach and help patients on how to go about finding needed resources, e.g., housing, babysitting, job, etc. (14, 15 and 16)

2. Assist patient in adjusting to new or present housing situation. (17)

3. Help patient/family plan and prepare moving to a new neighborhood. (18)

4. Assist patient/family adjust to present/new neighborhood. (19)

5. Provide social and recreational experiences to patients through individual contacts or activities. (21)

6. Provide social and recreational experiences to patients through small group activities. (22)

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*Number designation of task listed in Table 2.

7. Read and/or write letters for patients unable to read or write. (38)*

8. Provide social and recreational activities to patients or children in the waiting room. (29)

9. Maintain patient contact with the community by encouraging relatives to communicate with patients regarding adjustment at home with the family or in the community during or after home visits. (27)

10. Maintain patient contact with the community by encouraging patients to communicate problems while on leave from the hospital. (28)

11. Provide babysitting and other child care services to patients. (42)

12. Act as interpreter where language is a barrier.

13. Acquaint patients with available community resources. (8)

VI. Transportation and Escorting Services

1. Arrange transportation and travel for patients. (31)

2. Provide transportation for patients to clinics. (32)

3. Escort patients to clinics. (35)

4. Arrange for escort service such as the use of volunteers. (36)

VII. Advocacy and Facilitative Tasks

1. Assist in facilitating communication between the agency and community by clarifying agency programs to individuals. (24)

2. Assist in facilitating communication between the agency and community by conveying cultural patterns and attitudes to agency professional staff. (25)

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*Number designation of task listed in Table 2.

APPENDIX E

LIST OF HEALTH CARE FACILITIES SELECTED FOR NATIONAL SURVEY

BIRMINGHAM

200 Beds or More	Baroness Erlanger Hospital	Chattanooga, Tennessee
	Baptist Medical Center	Birmingham, Alabama
100-199 Beds	Jeff Anderson Memorial Hosp.	Meridian, Mississippi
	St. Judes Catholic Hospital	Montgomery, Alabama
Under 100 Beds	Sam Howell Memorial Hospital	Cartersville, Georgia
	Athens-Limestone Hospital	Athens, Alabama
Extended Care Fac.	Plantation Manor	McCalla, Alabama
	St. Lukes Nursing Home	Birmingham, Alabama

BOSTON

200 Beds or More	Peter Bent Brigham Hospital	Boston, Massachusetts
	Memorial Hospital	Worcester, Massachusetts
100-199 Beds	Faulkner Hospital	Boston, Massachusetts
	Thayer Hospital	Waterville, Maine
Under 100 Beds	Mary Lane Hospital	Ware, Massachusetts
	Falmouth Hospital	Falmouth, Massachusetts
Extended Care Fac.	Hebrew Rehab. Center for Aged	Boston, Massachusetts
	Cambridge Nursing Home	Cambridge, Massachusetts

CHICAGO

200 Beds or More	Chicago Wesley Memorial Hosp.	Chicago, Illinois
	Memorial Hospital	Kenosha, Wisconsin
100-199 Beds	Delnor Hospital	St. Charles, Illinois
	Beloit Memorial Hospital	Beloit, Wisconsin
Under 100 Beds	DeKalb Public Hospital	DeKalb, Illinois
	Bethany Brethren Hospital	Chicago, Illinois
Extended Care Fac.	Hearthside Nursing Home	Chicago, Illinois
	Fox River Rehab. Center	Chicago, Illinois

DENVER

200 Beds or More	St. Marys Hospital	Grand Junction, Colorado
	St. Lukes Hospital	Denver, Colorado
100-199 Beds	Memorial Hospital of Laramie County	Cheyenne, Wyoming
	Poudre Valley Memorial Hosp.	Fort Collins, Colorado
Under 100 Beds	Alamosa County Hospital	Alamosa, Colorado
	Longmont Community Hospital	Longmont, Colorado
Extended Care Fac.	Ivy Manor Nursing Home	Denver, Colorado
	Eventide Nursing Home	Longmont, Colorado

LOS ANGELES

200 Beds or More	Kaiser Foundation Hospital	Panorama City, California
	Santa Monica Hospital	Santa Monica, California
100-199 Beds	Morningside Hospital	Los Angeles, California
	West Valley Community Hosp.	Encino, California
Under 100 Beds	Community Hosp. of Gardena	Gardena, California
	Garden Park General Hospital	Anaheim, California
Extended Care Fac.	Kaiser Extended Care Fac.	Panorama City, California
	Culver City Convalescent Hospital	Los Angeles, California

SEATTLE

200 Beds or More	St. Francis Xavier Cabrini Hospital	Seattle, Washington
	Emmanuel Hospital	Portland, Oregon
100-199 Beds	St. Josephs Hospital	Aberdeen, Washington
	Vancouver Memorial Hospital	Vancouver, Washington
Under 100 Beds	Tri-State Memorial Hospital	Clarkston, Washington
	West Seattle General Hospital	Seattle, Washington
Extended Care Fac.	Mt. Baker Convalescent Home	Seattle, Washington
	L. C. Foss Sunset House	Seattle, Washington

SUPPLEMENTARY LIST OF FACILITIES

INCLUDED IN SOCIAL SERVICE TASK ANALYSIS SURVEY

NEW YORK

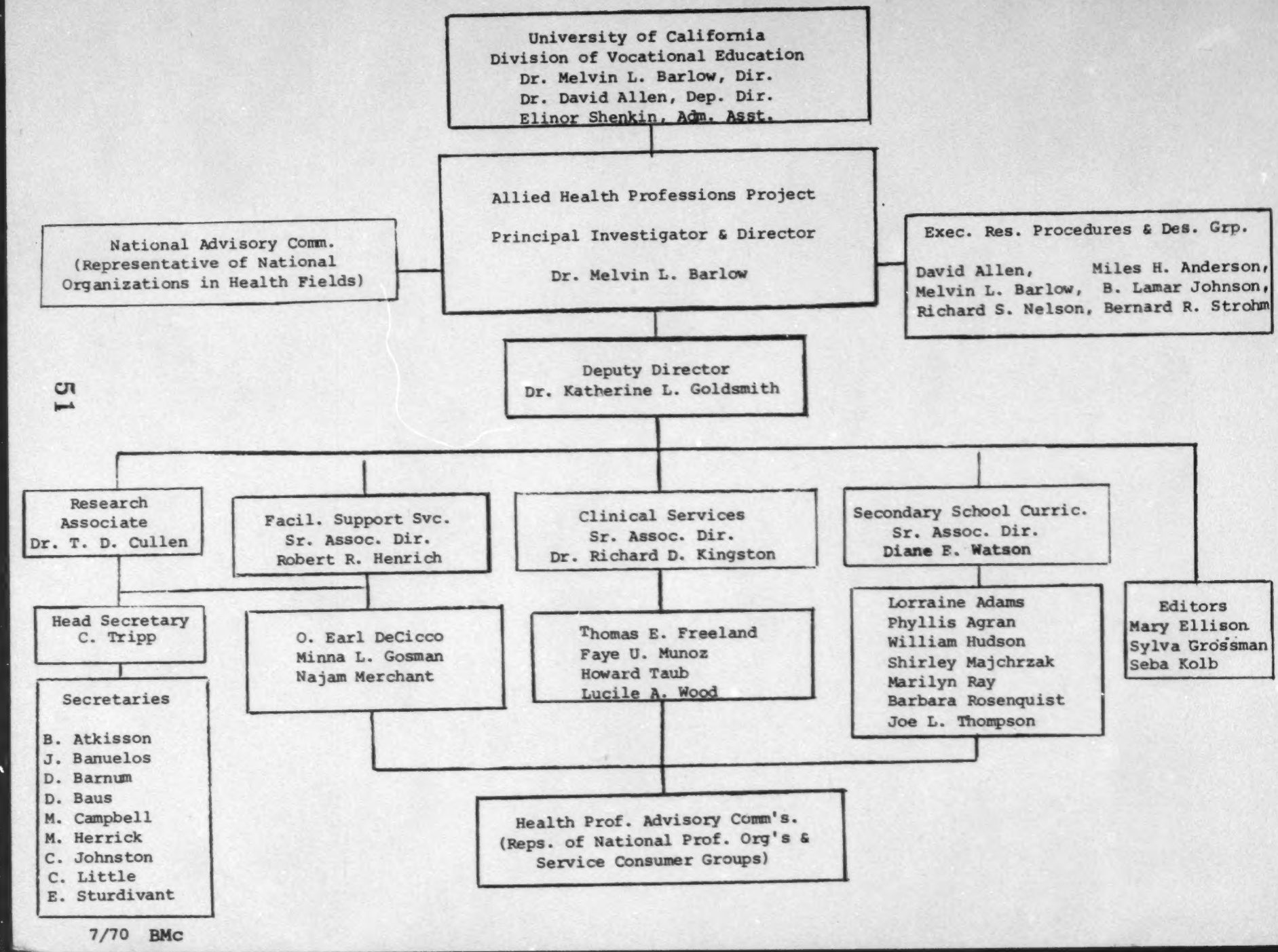
200 Beds or More	Beth Israel Medical Center, Gouverneur Health Service Program	New York, New York
	Dr. Martin Luther King Neighborhood Center, Montefiore Medical Center	Bronx, New York
	Maimonides Mental Health Center	Brooklyn, New York
	Mt. Sinai Hospital	New York, New York

DENVER

200 Beds or More	Fort Logan Mental Health Center	Denver, Colorado

CHICAGO

200 Beds or More	Presbyterian-St. Lukes Hospital	Chicago, Illinois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(Reps. of National Prof. Org's &
Service Consumer Groups)

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